Leng Review Call for Evidence – background paper on scopes of practice

March 2025

1. About the Professional Standards Authority

1.1 The Professional Standards Authority for Health and Social Care (PSA) is the UK's oversight body for the regulation of people working in health and social care. Our statutory remit, independence and expertise underpin our commitment to the safety of patients and service-users, and to the protection of the public.

1.2 There are 10 organisations that regulate health professionals in the UK and social workers in England by law. We audit their performance and review their decisions on practitioners' fitness to practise. We also accredit and set standards for organisations holding registers of health and care practitioners not regulated by law.

1.3 We collaborate with all of these organisations to improve standards. We share good practice, knowledge and our Right-touch regulation expertise. We also conduct and promote research on regulation. We monitor policy developments in the UK and internationally, providing guidance to governments and stakeholders. Through our UK and international consultancy, we share our expertise and broaden our regulatory insights.

1.4 Our core values of integrity, transparency, respect, fairness, and teamwork, guide our work. We are accountable to the UK Parliament. More information about our activities and approach is available at www.professionalstandards.org.uk.

2. Introduction

2.1 We submit this paper to the Leng Review (the Review) Call for Evidence as 'other relevant analysis'. We confirm that it has not been published elsewhere.

2.2 The aim of this paper is to set out considerations in relation to scopes of practice of health and care professionals. This issue has been central to the debates about the safety of the physician associate (PA) and anaesthesia associate (AA) roles.

2.3 This paper does not take a position on scopes of practice for PAs and AAs, rather it sets out the policy context, and provides some parameters for policy-making. We hope this will be helpful for the Review's thinking about whether it is necessary or desirable to define scopes of practice, and what the professional regulator's role should be therein. In particular, we hope it will be helpful in its consideration of "*who should have responsibility in the health system in relation to setting out guidance and standards on training and working for the*

profession, to address current confusion in leadership roles", [1] and to "*help ensure that any future role innovation and skill mix changes will build patient and professional confidence and trust"*.[2]

3. Background: regulation of AAs and PAs

3.1 Debates about scopes of practice have been a key focus of discussion about the regulation of PAs and AAs by the General Medical Council (GMC) in the UK, which came into force in December 2024.

3.2 In relation to PAs and AAs, the GMC describes its role as being to:

- set the standards of patient care and professional behaviours PAs and AAs need to meet
- set the outcomes and standards that students qualifying from PA and AA courses must meet to join our register, and approve the curricula that courses must deliver
- check who is eligible to work as a PA or AA in the UK and check they continue to meet the professional standards we set throughout their careers
- give guidance and advice to help PAs and AAs understand what's expected of them
- investigate where there are concerns that patient safety, or the public's confidence in PAs and AAs, may be at risk, and take action if needed[3].

3.3 The GMC has not set out a scope of practice for PAs and AAs, and nor does it have one for doctors. Several of the Royal Colleges are developing scopes of practice for PA and AA roles as relevant to their remit, such as the Royal College of GP's scope of practice for PAs[4]. In August 2024, the GMC wrote to the RCGP about the guidance, and whilst it recognised that it could be helpful to professionals and employers, it expressed concerns that in places it may be overly restrictive.[5]

3.4 Concerns have been raised by individuals and organisations that the lack of an agreed, defined scope of practice (or practices) for these roles could lead to difficulties in holding individuals to account, and to failures of patient safety. These include Anaesthesia United's judicial review challenge, which claims the GMC should have introduced a scope of practice for PAs and AAs. Permission has been granted by the High Court and the case will be heard on 13 May 2025. In reaching his decision, Mr Justice Chamberlain observed that "The claim raises serious issues of importance to the relevant professions and to patients which should be determined on a reasonably expedited basis."[6]

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[1] Leng review: further detail on the areas to be covered by the review of physician associate and anaesthesia associate professions - GOV.UK
[2] Leng review: independent review of physician associate and anaesthesia associate professions terms of reference - GOV.UK
[3] Regulating physician associates and anaesthesia associates - GMC
[4] Physician Associates in general practice: Scope of practice
[5] gmc-response-on-rcgp-pa-guidance-06-08-2024_pdf-109476158.pdf
[6] Court gives us the go-ahead - Anaesthetists United

4. Policy context: scopes of practice and regulation

4.1 'Scope of practice' generally refers to the range of tasks that would be considered appropriate and safe for someone carrying out a particular role to undertake, although as noted below, there is no agreed definition to this term in the UK in the context of health and care professional regulation. They can also have the effect of delineating boundaries between different professions.

4.2 Scopes of practice have not been a significant feature of professional regulation within the UK to date. Leslie et al[7] observe that '*Among the 10 professional regulators in the UK, there is no common approach to determining scope of practice, nor is there any agreed definition of scope of practice'*. The authors note that this contrasts with the approach taken in other countries such as Canada, which has typically defined in legislation tasks, which may only be undertaken by a particular profession.[8] This approach is sometimes referred to as 'protection of task', and may be underpinned by penalties for people who undertake the tasks outside of the conditions set in the legislation, similar to protection of title. In British Columbia, for example this sits alongside indicative scopes of practice set out in guidance.[9] In Ontario, scopes are defined only in legislation.[10]

4.3 In the UK, the General Dental Council (GDC) is to our knowledge the only regulator to have defined scopes of practice for the roles it registers. The practice of dentistry is defined, and protected, in broad terms in the Dentists Act 1984,[11] but they have also issued non-statutory guidance setting out scopes of practice for everyone in the dental team.[12][13]

4.4 The Welsh Assembly Government's recent consultation on the introduction of Nursing Associates in Wales included a proposal for the Government to define scopes of practice. This approach would contrast with the current approach to regulating this role in England. Our response to the consultation highlighted the potential impacts of divergence between the nations of the UK, and the need to consider and manage implications for the regulation of nursing associates by the Nursing and Midwifery Council (NMC).[14]

4.5 Scopes of practice are relevant to debates about regulation of advanced practice. For several years now, people have been raising concerns about nurses and other professions working at an advanced level, undertaking tasks

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[7] Leslie, K., Moore, J., Robertson, C. et al. Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia and the UK. Hum Resour Health 19, 15 (2021). https://doi.org/10.1186/s12960-020-00550-3

[8] https://www.ontario.ca/page/regulated-health-professions#:~:text=There%20are%2027%20regulated%20health%20professions%20in%20Ontario,titles%20that%20members%20of%20the%20profession%20may%20use

[9] Shared Scope of Practice and Restricted Activities - Province of British Columbia

[10] Regulated health professions | ontario.ca

[11] https://www.legislation.gov.uk/ukpga/1984/24/section/37

[12] https://www.gdc-uk.org/docs/default-source/scope-of-practice/scope-of-practice.pdf

[13] This is in the process of being substantially revised, including to reduce the extent to which it demarcates between professions. See here; Scope of Practice

[14] https://www.professionalstandards.org.uk/publications/response-welsh-government-consultation-parameters-practice-nursing-associates

which, they argue, go beyond the scope of practice and training of registrants.[1516] This has led to a working group being set up between the three regulators for whom this is a relevant concern, the NMC, HCPC, and SWE. There is however currently no consensus about whether there are currently unregulated risks in this area, and if there are, whether they require additional regulatory mechanisms, such as an annotation on the register accompanied by further approved training.[1718]

4.6 Scopes of practice do not feature as part of the PSA's current Standards of Good Regulation for the statutory regulators. They are referred to within the Evidence Framework for the Accredited Registers (ARs) as an example of how a register can demonstrate that it has clear standards of competence. Arguably, because the Accredited Registers programme covers roles that are not regulated by statute, there may be greater need for this clarity through the Standards for ARs. For the statutory regulators, there is a much broader group of stakeholders, such as the Royal Colleges, who play a role in developing guidance and training that can be considered as contributing to the framework for determining competence.

4.7 The PSA has not to date taken a formal position in relation to the role of scopes of practice within professional regulation. However, it was supportive of the GDC's proposals to build greater flexibility into their scopes of practice for the dental team, in its response to the May 2023 consultation.[19]

4.8 Any changes in policy for existing professions regulated by statute would need to consider whether legislative changes would be needed as a consequence.

5. Discussion

5.1 The scale of workforce change that will be needed to deliver health and care in the context of increasing economic and social pressures, and an ageing population with increasingly complex needs, means we can expect to see new roles being developed and existing roles needing to evolve. Some of this is likely to be a continuation of the proliferation of support roles that we have seen since the early 2000s across all sectors, and most recently in healthcare with nursing, physician, and anaesthesia associates.[2021] The greatest impacts though could arise from the changes in the way care is delivered, which are likely to require existing occupations to evolve, and new roles beyond just support roles to emerge.[22] All of this may entail a (re)drawing of the boundaries between occupations – and the question of how to do so safely and appropriately is therefore set to become increasingly relevant.

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[15] 190911-The-evolution-of-advanced-nursing-practice-past-present-and-future.pdf
[16] LSBU expert argues for investment in specialist nurses | London South Bank University
[17] Advanced practice review - The Nursing and Midwifery Council
[18] Updates on Advanced Practice | The HCPC
[19] Professional Standards Authority response to GDC consultation on updating its Scope of Practice guidance | PSA
[20] ResearchGate
[21] Policy on new workforce roles: A discussion paper - ScienceDirect
[22] Contested professional role boundaries in health care: a systematic review of the literature. - Abstract - Europe PMC

5.2 In order to determine a) whether definition of scopes of practice are needed, and b) whether regulation has a part to play within that, it is important to define and understand the problem.

5.3 The PSA's *Right-touch regulation* (RTR) approach provides a framework for considering policy problems in healthcare, to identify whether and how regulation may be needed – see also the RTR decision tree at Annex A. It is predicated on the idea that formal regulatory mechanisms should be used only to address risk of harm, and where other mechanisms are insufficient to manage these risks.

5.4 It encourages us to ask the following questions:

1. What is the problem we're trying to solve?
2. Is it about risk of harm?
3. How great are the risks and what kinds of risks are they?
4. Are there existing mechanisms to manage them and could these be improved?
5. Could the problems be managed locally? If not, what regulatory solutions are available?
6. If there are possible regulatory solutions, do they come with unintended consequences that might outweigh the benefits of regulating?

5.5 We set out below some of the considerations the Review might want to apply to this question.

Defining the problem and assessing the risks

5.6 As the Review will be aware, the debate around the expansion of PA and AA roles has touched on a number of different issues. For example, some doctors have simply wanted to highlight that PAs and AAs are being deployed in ways that put patients at risk, as a consequence of being asked or allowed to take on tasks for which they are not properly trained. Others have raised concerns about their role in supervision in the absence of a nationally defined scope of practice for PAs and AAs, citing patient safety and additional individual burden. Some have also expressed dissatisfaction about the perceived blurring of professional boundaries and cited concerns about pay. Further concerns have highlighted how in general practice, the introduction of PAs is having the paradoxical effect of freeing up GPs not for more complex cases but for the growing volume of administrative work.[23]

5.7 The Review's focus on evidence of risks to patient safety should enable it to identify which, among these concerns, relate most closely to patient safety, and may enable some qualification and quantification of the risks.

Existing mechanisms, including local mechanisms

5.8 While it may be necessary for scopes of practice to be set, it may not be necessary for this to be done by the professional regulator. Employers can play

[23] A contentious intervention to support the medical workforce: a case study of the policy of introducing physician associates in the United Kingdom. - Abstract - Europe PMC

an important role in determining an individual's scope of practice. Where that employer is the NHS, there are HR tools, which could have the effect of defining a consistent scope of practice for a particular role, through standardised job descriptions for example. Royal colleges and professional bodies can also play a part here.

5.9 For some roles, such as PAs and AAs, supervision by more senior professionals – in this case, doctors – is a key part of assurance that someone is working within their scope of practice.

5.10 On an individual level, professional judgement, education pathways and professional experience all contribute to safety when it comes to working within one's scope of competence. The professional regulators already have a role in all three areas through existing mechanisms. Professional standards and codes include clear commitments to work within one's scope of competence.[24] Often working closely with royal colleges, regulators set the learning outcomes for qualifying training, and quality assure education providers. They also have a role in checking ongoing professional development. This can range from continuing professional development (CPD) to formal revalidation schemes, currently in place for doctors and nurses.

5.11 We urge the Review to consider carefully what could be done through non-regulatory mechanisms, noting that this may nonetheless involve some reinforcement of existing frameworks.

Possible regulatory solutions

5.12 If non-regulatory approaches are considered inadequate for the purpose of managing the risks identified, there would still be a range of options for regulating scopes of practice, including:

- Protection of core task(s) in legislation, flexibility of scopes outside of the core tasks
- Definition of core tasks in guidance
- Defining scopes of practice only for a set period post-qualification (e.g. 2 years)

5.13 In line with the principles of Right-touch regulation, we recommend that the chosen solution uses the minimum regulatory force to achieve the desired result.

Unintended consequences

5.14 This is, in our view, one of the central questions for the Review's consideration of this issue.

5.15 There are potentially significant drawbacks to having defined scopes of practice, particularly if they are highly restrictive, and/or difficult to amend by virtue of being enshrined in legislation, or because of stakeholder interests and pressures.

[24] For example, from the NMC Code of Practice: "*13. Recognise and work within the limits of your competence*" (available at: The Code)

5.16 The way scopes are managed for existing healthcare professions can be summed up as *"a combination of qualifications and training, various laws (including those pertaining to negligence) and shared understandings both intra-professionally and with the public about what the limits of good practice ought to be".*[25] This perhaps fragile equilibrium could be disturbed by a decision to take a radically different approach for one profession, particularly if it works closely with others.

5.17 As we set out above, flexibility in role definition is likely to be increasingly valuable to enable roles to adapt to fast-paced changes in the delivery of care. This came into sharp focus during the Covid-19 pandemic, when health professionals were sometimes required to undertake tasks outside of their usual scopes. In Ontario, legislation was required to allow healthcare professionals to work outside their usual scope of practise.[26]

5.18 Where scopes are defined, this can have a calcifying effect on the boundaries between professions. This can come from the professions themselves, as scopes constitute a mechanism for enforcement of "occupational closure".[27] Any attempt to shift them can trigger professional boundary disputes.

5.19 Indemnifiers also have a stake in the scopes debate, as they may use them to determine the boundaries of indemnity cover.[28] As a consequence, indemnity providers may have a financial interest in their being tightly defined.

5.20 Research suggests that restrictive scopes of practice for PA-type roles can contribute to hesitancy by employers in recruiting and developing these roles, and make their integration into the workplace more challenging.[29]

5.21 It is worth noting that even where scopes are not intended to be tightly defined, in practice this can be how they are interpreted by professionals – an indicative list of tasks can become an exhaustive list in the eyes of the profession to which it applies. This appears to be the case for the scopes of practice for the dental team developed by the GDC.[30]

5.22 Policy-making in this area will need to ensure that any potential benefits of a defined scope of practice are not outweighed by problematic unintended consequences.

6. Conclusions

6.1 We know that optimising flexibility in the workforce is going to be increasingly important in the future, and so we need to think carefully about how to balance this with safety and accountability.

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[25] A contentious intervention to support the medical workforce: a case study of the policy of introducing physician associates in the United Kingdom. - Abstract - Europe PMC
[26] Expanding Scope of Practice for Ontario Regulated Health Professionals during COVID-19
[27] Contested professional role boundaries in health care: a systematic review of the literature
[28] scope-of-practice-consultation-paper.pdf
[29] Factors influencing the development, recruitment, integration, retention and career development of advanced practice providers in hospital health care teams: a scoping review. - Abstract - Europe PMC
[30] GDC launches consultation on Scope of Practice

6.2 If Right-touch regulation is correctly applied to the questions ‘should X profession have a defined scope of practice?’ and ‘should X’s regulator play a role in defining scopes of practice?’, it seems likely from what we have set out in this paper that the answers may differ from one profession to another. This would simply reflect the differences in risks, practice contexts and stakeholder landscapes across different occupations in healthcare. It may also suggest taking a different approach for new professions, as compared to existing ones.

6.3 As mentioned above, the current approach for existing healthcare professions is complex. We also do not necessarily know how well it is working, and future decisions on managing scopes of practice should consider whether there is evidence of safety gaps in the ways they are managed currently for the existing professions.

7. Annex A: Right-touch regulation decision tree

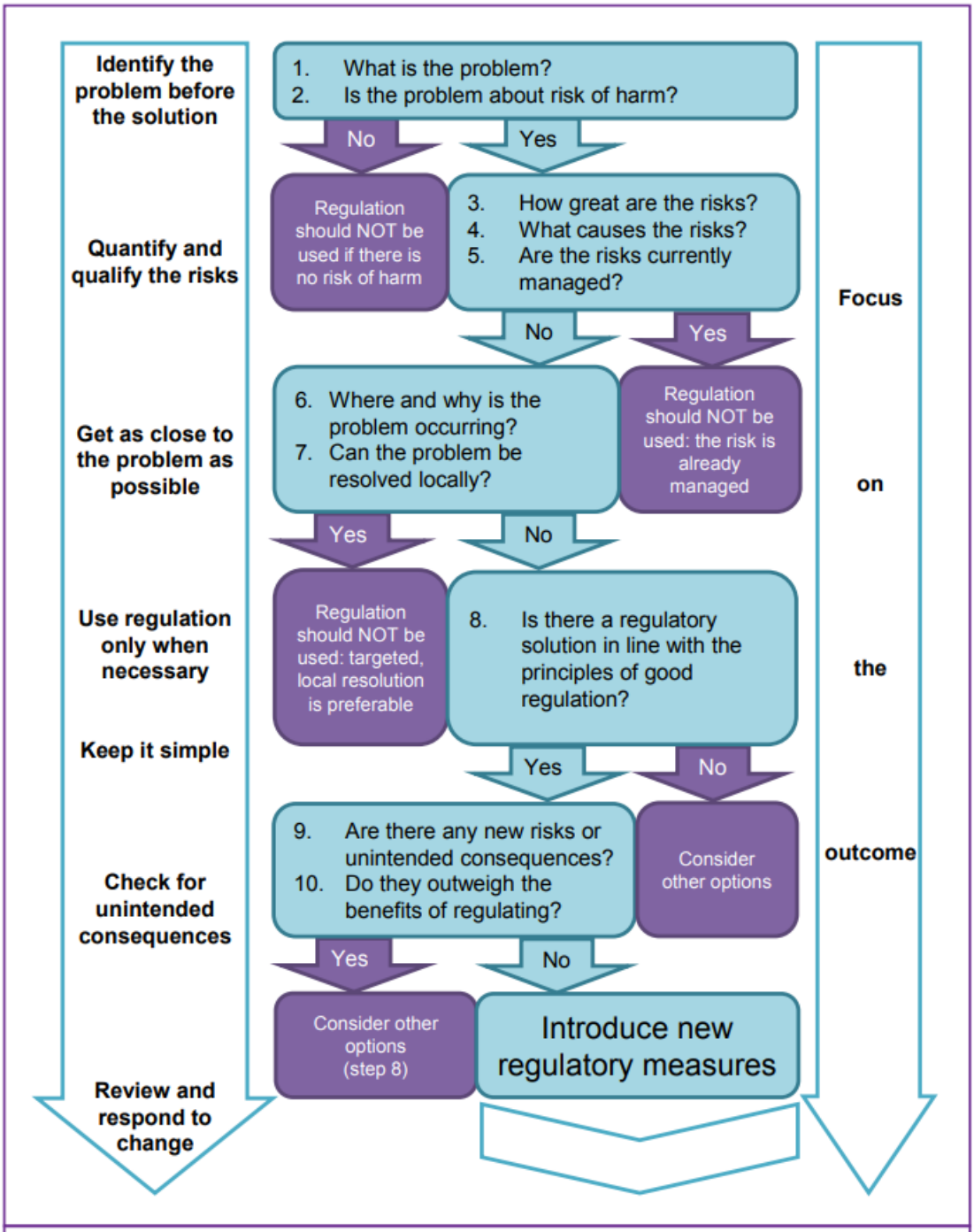

Figure 2. The Right-touch regulation decision tree.

From Right-touch regulation, available at: [Right-touch regulation | PSA]